Minnesota Advantage Health Plan 2014-2015 Benefits Schedule

2014-2015 Benefit Provision	**Cost Level 1** - You Pay	**Cost Level 2** - You Pay	**Cost Level 3** - You Pay	**Cost Level 4** - You Pay
A. Preventive Care Services • Routine medical exams, cancer screening • Child health preventive services, routine immunizations • Prenatal and postnatal care and exams • Adult immunizations • Routine eye and hearing exams	Nothing	Nothing	Nothing	Nothing
B. Annual First Dollar Deductible (single/family)	$75/$150	$180/$360	$400/$800	$1,000/$2,000
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care • Outpatient visits in a physician's office • Chiropractic services • Outpatient mental health and chemical dependency • Urgent Care clinic visits (in or out of network)	$18/23* copay per visit Annual deductible applies	$23/28* copay per visit Annual deductible applies	$36/41* copay per visit Annual deductible applies	$55/60* copay per visit Annual deductible applies
D. In-network Convenience Clinics and Online Care (deductible waived)	$10 copay	$10 copay	$10 copay	$10 copay
E. Emergency Care (in or out of network) • Emergency care received in a hospital emergency room	$100 copay Annual deductible applies	$100 copay Annual deductible applies	$100 copay Annual deductible applies	25% coinsurance Annual deductible applies
F. Inpatient Hospital Copay (waived for admission to Center Of Excellence)	$100 copay Annual deductible applies	$200 copay Annual deductible applies	$500 copay Annual deductible applies	25% coinsurance Annual deductible applies
G. Outpatient Surgery Copay	$60 copay Annual deductible applies	$120 copay Annual deductible applies	$250 copay Annual deductible applies	25% coinsurance Annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	Nothing	Nothing
I. Prosthetics, Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance Annual deductible applies
J. Lab (including allergy shots), **Pathology, and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments)	5% coinsurance Annual deductible applies	5% coinsurance Annual deductible applies	20%coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
K. MRI/CT Scans	5% coinsurance Annual deductible applies	10% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance annual deductible applies

L. Other expenses not covered in A-K above, including but not limited to:
• **Ambulance**
• **Home Health Care**
• **Outpatient Hospital Services** (non-surgical)
  • Radiation/chemotherapy
  • Dialysis
  • Day treatment for mental health and chemical dependency
  • Other diagnostic or treatment related outpatient services
	5% coinsurance
	annual deductible applies
		5% coinsurance
		annual deductible applies
			20% coinsurance
			annual deductible applies
				25% coinsurance
				annual deductible applies

M. Prescription Drugs 30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin, or a 3-cycle supply of oral contraceptives **Note: all Tier 1 generic and select branded oral contraceptives are covered at no cost.**	$12/$18/$38	$12/$18/$38	$12/$18/$38	$12/$18/$38
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility, growth hormones) (single/family)	$800/$1,600	$800/$1,600	$800/$1,600	$800/$1,600
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$1,100/2,200	$1,100/2,200	$1,500/3,000	$2,500/5,000

**The level of the office visit copayment for the employee and his or her family is dependent upon whether the employee has completed the Health Assessment in each Open Enrollment period, and agreed to accept a health coach call. Employees who have completed the Health Assessment and agreed to accept a health coach call are entitled to the lower copayment. Employees hired after the close of Open Enrollment will be entitled to the lower copayment.*

This chart applies only to in-network coverage. Out-of-Network coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves]. It is also available to dependent children, including college students, and spouses living out of area. These members pay a $350 single or $700 family deductible and 30% coinsurance to the out-of-pocket maximum described in Section O above. Members pay the drug copayment described at Section M above to the out-of-pocket maximum described at Section N.

A standard set of benefits is offered in all SEGIP Advantage plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefits are administered, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.